26. Personal care services. (continued)

qualified professional. For the purposes of this item, "qualified professional" means a registered nurse or a mental health professional defined in item 6.d.A. of this attachment;

d) is not a consumer of personal care services; and

e) is subject to criminal background checks and procedures specified in the state human services licensing act.

- Effective July 1, 1996, personal care provider organization means an entity enrolled to provide personal care services under medical assistance that complies with the following:

a) owners who have a five percent interest or more, and managerial officials are subject to a background study. This applies to currently enrolled personal care provider organizations and those entities seeking to enroll as a personal care provider organization. Effective November 10, 1997, an organization is barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in the state human services licensing act, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in the state human services licensing act;

b) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provide proof thereof. The insurer must notify the Department of the cancellation or lapse of policy; and

26. Personal care services. (continued)

c) the organization must maintain documentation of personal care services as specified in rule, as well as evidence of compliance with personal care assistant training requirements.

**B. PCA Choice option**

Under this option, the recipient and qualified professional do not require professional delegation.

- The recipient or responsible party:

a) uses a PCA Choice provider, not a personal care provider organization. A PCA Choice provider assists the recipient to account for covered personal care assistant services. A PCA Choice provider is considered a joint employer of the qualified professional described in item A and the personal care assistant, and may not be related to the recipient, qualified professional, or personal care assistant. A PCA Choice provider or owner of the entity providing PCA Choice services must pass a criminal background check according to the state human services licensing act;

b) uses a qualified professional for help in developing and revising a plan to meet the recipient's assessed needs and for help in supervising the personal care assistant services, as recommended by a public health nurse;

c) supervises the personal care assistant if there is no qualified professional;

d) with the PCA Choice provider, hires and terminates the qualified professional;

e) with the PCA Choice provider, hires and terminates the personal care assistant;

26. Personal care services. (continued)

c) the use of the option results in abusive or fraudulent billing.

The recipient or responsible party may appeal this decision. A denial, revocation or suspension will not affect the recipient's authorized level of personal care assistant services.

Amount, duration and scope of personal care services:

- Department prior authorization is required for all personal care services and supervision. Prior authorization is based on the physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; primary payer coverage determination information as required; the service plan; and cost effectiveness when compared to other care options. The Department may authorize up to the following amounts of personal care service:

  a) up to 2 times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level;

  b) up to 3 times the average number of direct care hours provided in nursing facilities for recipients with complex medical needs, or who are dependent in at least seven activities of daily living and need either physical assistance with eating or have a neurological diagnosis;

  c) up to 60 percent of the average payment rate for care provided in a regional treatment center for recipients who exhibit, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors:

     1) self-injury;
     2) physical injury to others; or
     3) destruction of property;

26. Personal care services. (continued)

d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or

e) up to the amount medical assistance would pay for facility care for recipients referred by a preadmission screening team; and

f) a reasonable amount of time for the provision of supervision of personal care services.

- Department prior authorization is also required if more than two reassessments to determine a recipient's need for personal care services are needed during a calendar year.

- Personal care services must be prescribed by a physician. The service plan must be reviewed and revised as medically necessary at least once every 365 days.

- For personal care services

a) effective July 1, 1996, the amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers;

b) effective July 1, 1996, if the recipient's medical need changes, the recipient's provider may request a change in service authorization; and

c) as of July 1, 1998, in order to continue to receive personal care services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B. of this attachment.

26. Personal care services. (continued)

must document the following in the health service record for each recipient sharing services:

a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;

b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;

c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;

d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;

e) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of shared services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;

f) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

g) daily documentation of the shared services provided by each identified personal care assistant including:

1) the names of each recipient receiving share services together;

26. Personal care services. (continued)

2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

In order to receive shared services:

a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:

1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared services allocated as part of the overall authorization of personal care services;

b) the recipient or responsible party, in conjunction with the supervising qualified professional, must arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the supervising qualified professional, must consider and document in the recipient's health service record:

1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

26. Personal care services. (continued)

h) assistance with furnishing medication that is self-administered;

i) application and maintenance of prosthetics and orthotics;

j) cleaning medical equipment;

k) dressing or undressing;

l) assistance with eating, meal preparation and necessary grocery shopping;

m) accompanying a recipient to obtain medical diagnosis or treatment;

n) effective July 1, 1996, assisting, monitoring, or prompting the recipient to complete the services in items (a) to (m);

o) effective July 1, 1996, redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care described in items (a) to (n);

p) effective July 1, 1996, redirection and intervention for behavior, including observation and monitoring;

q) effective July 1, 1996, interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

r) effective July 1, 1998, tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure may be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean, rather than a sterile

26. Personal care services. (continued)

The hardship waiver criteria are:

1) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

2) the relative goes from a full-time job to a part-time job with less compensation to provide personal care for the recipient;

3) the relative takes a leave of absence without pay to provide personal care for the recipient;

4) the relative incurs substantial expenses by providing personal care for the recipient; or

5) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient.

d) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;

e) services provided by the residential or program license holder in a residence for more than four persons;

26. Personal care services. (continued)

f) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

g) sterile procedures;

h) giving of injections of fluids into veins, muscles, or skin;

i) homemaker services that are not an integral part of a personal care service;

j) home maintenance or chore services;

l) personal care services when the number of foster care residents is greater than four;

m) personal care services when ~~combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most~~ other, more cost-effective, medically appropriate services are available;

n) services not specified as covered under medical assistance as personal care services;

o) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

p) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care

26. Personal care services. (continued)

assistant, unless case management is provided (applies to foster care settings);

q) effective January 1, 1996, personal care services that are not in the service plan;

r) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

s) services to other members of the recipient's household;

t) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

u) personal care services that are not ordered by the physician; or

v) services not authorized by the commissioner or the commissioner's designee.

26. Personal care services. (continued)

b) assessments, reassessments and service updates are not required;

c) Department prior authorization is not required;

d) a physician need not review the IEP;

e) a personal care assistant is supervised by a registered nurse, public health nurse, school nurse, occupational therapist, physical therapist, or speech pathologist;

f) service limits as described in this item do not apply;

g) PCA Choice is not an option;

h) only the following services are covered:

1) bowel and bladder care;

2) range of motion and muscle strengthening exercises;

3) transfers and ambulation;

4) turning and positioning;

5) application and maintenance of prosthetics and orthotics;

6) dressing or undressing;

7) assistance with eating, nutrition and diet activities;

8) redirection, monitoring, observation and intervention for behavior; and

9) assisting, monitoring, or prompting the recipient to complete the services in subitems 1) through 8).

26. Personal care services. (continued)

- To receive personal care services, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- School districts must secure informed consent to bill for personal care services. For the purposes of this item, "informed consent" means a written agreement, or an agreement as documented in the record, by a recipient or responsible party in accordance with Minnesota Statutes, section 13.05, subdivision 4, paragraph (d) and Minnesota Statutes, section 256B.77, subdivision 2, paragraph (p).

2.a. Outpatient hospital services.

- All services must be provided by or under the on-site supervision of a physician or dentist.

- Outpatient day treatment or partial hospital programs for mental illness ~~must be approved by the state agency as eligible for MA payment~~ require prior authorization as specified in the *State Register*. ~~Prior authorization is required before initial treatment for partial hospital programs and every 30 days thereafter for outpatient day treatment and partial hospital programs.~~

- Nutritional counseling exceeding three visits requires prior authorization.

- Outpatient chemical dependency programs are provided for under rehabilitation services. Limitations for outpatient chemical dependency programs are provided under Item 13.d. of this attachment.

- Blood and blood components are covered to the extent these are not available from other sources. Blood charges may not exceed the cost of the quantity actually administered and not replaced.

- Outpatient hospital services includes end-stage renal disease hemodialysis. A recipient receiving hemodialysis in the home is considered to be receiving outpatient hospital services.

- Supplies and equipment ordinarily furnished by hospitals during the care and treatment of an illness or injury are not separately payable.

- Hospitals must comply with federal regulations concerning informed consent for voluntary sterilization procedures and hysterectomies.

- Second surgical opinion is a condition of reimbursement for tonsillectomy and/or adenoidectomy, hysterectomy, and cholecystostomy.

2.a. Outpatient hospital services. (continued)

- Abortion related services are covered when the abortion is medically necessary to prevent the death of a pregnant woman, and in cases where the pregnancy is the result of rape and incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

- Coverage of physical therapy, occupational therapy, audiology, and speech language pathology is limited to services within the limitations provided under items 11.a. to 11.c., physical therapy and related services.

- Providers who administer pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program.

5.a. Physicians' services:

- **Psychiatric services**: Coverage is limited to the following services. Services require prior authorization as specified in the *State Register*:

| Services | Limitations |
|---|---|
| Diagnostic assessment | 1 assessment of up to two hours per calendar year or up to 4 assessments per calendar year, unless the recipient meets certain medical criteria established in rule; if so, MA will pay for 1 assessment of up to 8 hours. |
| Psychological testing | 32 units per calendar year. |
| Neuropsychological assessment | 28 units per calendar year. |
| Individual psychotherapy, 20 to 30 minutes | Individual psychotherapy and one half hour units of biofeedback training combined, are covered up to 26 hours per calendar year~~, not more frequently than once every 5 calendar days, unless additional coverage is prior authorized~~. * |
| Individual psychotherapy, 40 to 50 minutes | Individual psychotherapy and one hour units of biofeedback training combined, are covered up to 20 hours per calendar year~~, not more frequently than once every 10 calendar days, unless additional coverage is prior authorized~~. * |
| Individual psychotherapy discretionary | Up to 6 hours per calendar year. |

5.a. Physicians' services (continued):

| Services | Limitations |
|---|---|
| Family psychotherapy without patient present | ~~Not more frequently than once every 5 calendar days,~~ Up to 20 hours per calendar year when combined with family psychotherapy~~, unless additional coverage is prior authorized~~.* |
| Family psychotherapy | ~~Not more frequently than once every 5 calendar days,~~ Up to 20 hours per calendar year when combined with family psychotherapy without patient present~~, unless additional coverage is prior authorized~~.* |
| Family psychotherapy discretionary | Up to 6 hours per calendar year. |
| Multiple family group psychotherapy | Up to 10 times per calendar year, not to exceed 2 hours per occurrence.* |
| Group psychotherapy | Up to 78 hours per year, not to exceed 3 hours within a 5 calendar day period.* |
| Chemotherapy management including prescription, use, and review of medication with not more than minimal medical psychotherapy - provided the medication required is antipsychotic or antidepressant provided by a physician, clinical nurse specialist with a specialty in psychiatric nursing or mental health, or registered nurse who is also a mental health professional or practitioner and is employed or under contract with the physician or provider who is providing clinical supervision. | 52 clinical units per calendar year, not more than 1 unit per week. |

5.a. Physicians' services (continued):

| Services | Limitations |
|---|---|
| Electroconvulsive therapy single seizure | |
| Multiple seizures, per day | |
| Explanation of findings | 4 hours per calendar year. |
| Unlisted psychiatric service or procedure | |
| Biofeedback training | One-half hour units of service are subject to the same limitations as individual psychotherapy, 20 to 30 minutes. One hour units of service are subject to the same limitations as individual psychotherapy, 40 to 50 minutes.* |

* ~~In addition to these limits, unless additional coverage is prior authorized, more than 1 *type* of therapy (group, family, or individual, except for discretionary therapy) is not covered if provided more frequently than once every 5 calendar days, nor is more than a 1-hour unit of individual psychotherapy or a 1-hour unit of biofeedback training covered if provided within 10 calendar days of a ½-hour unit of individual psychotherapy (90843), or a ½-hour unit of biofeedback training.~~

5.a. Physicians' services (continued):

- **Organ transplants**: These services are covered in accordance with the standards and statutory authority provided in Attachment 3.1-E.

- **Physical therapy, occupational therapy, ~~audiology~~ and speech, language, ~~pathology~~ and hearing therapy services**: Coverage of these services is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- **Anesthesia services:** Anesthesiologists may personally perform or may medically direct (supervise) the services.

- **Physician services to pregnant women**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to pregnant women.

- **Physician services to children under 21 years of age**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to children under 21 years of age.

- **Pediatric vaccines**: Physicians who administer certain pediatric vaccines (i.e., vaccines that are part of the Minnesota Vaccines for Children Program) within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program. The Minnesota Vaccines for Children Program is established pursuant to §1928 of the Act.

7.c. Medical supplies, equipment and appliances suitable for use in the home.

- Covered medical supplies, equipment and appliances suitable for use in the home are those ~~which~~ that are: (a) medically necessary; (b) offered by a physician; (c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and (d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)~~, or licensed health care facility~~.

- Medical supplies and equipment ordered in writing by a physician are paid with the following limitations:

  1) A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one-month supply.

  2) Maintenance or service made at routine intervals based on hours of use or calendar days to ensure that equipment in proper working order is ~~reimbursable~~ payable.

  3) The cost of a repair to durable medical equipment that is rented or purchased by the Medical Assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by the warranty.

  4) In the case of rental equipment, the sume of rental payments during the projected period of the recipient's use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

- **Augmentative and alternative communication devices** are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices.